Figure 2-20-N-10 Appeals (Continued)

Health Care Financing Administration's contractor (The Center for Health Dispute Resolution) for a decision.

72-Hour Appeal Process
(Does not apply to denials of payment)

If you want to file an appeal which will be processed within 72 hours do the following:

- File an oral or written request for a 72-hour appeal. Specifically state that "I want an: expedited appeal, fast appeal or 72-hour appeal." or "I believe that my health could be seriously harmed by waiting 60 days for a normal appeal."
- To file a request orally, call *[phone number]*. *[name of HMO]* will document the oral request in writing.
- To hand deliver your request, our address is *[specific HMO address]*.
- To FAX your request, our FAX number is*[FAX number]*. If you are in a hospital or a nursing facility, you may request assistance in having your written appeal transmitted to *[name of HMO CMP]* by use of a FAX machine.
- To mail a written request, our address is: *[HMO CMP Appeal Department address]* however, the 72-hour review time will not begin until your request for appeal is received.
- You must file your request within 60 days of the *[date of this notice]* which is *[date]*.

[HMOs with other options for accepting appeal requests should describe them here. For example delivering appeals requests in person to a member services office. Also include information here on how the beneficiary may provide additional information.)

10-Day Extension

An extension up to 10 working days is permitted for a 72-hour appeal, if the extension of time benefits you, for example, if you need time to provide *[HMO name]* with additional information or if we need to have additional diagnostic tests completed.

We will make a decision on your appeal and notify you of it within 72-hours of receipt of your request. However, if our decision is not fully in your favor, we will automatically forward your appeal request to the Health Care Financing Administration's contractor, (The Center for Health Dispute Resolution (The Center)), for an independent review. The Center will send you a letter with their decision within 10 working days of receipt of your case from *[name of HMO CMP]*.

Figure 2-20-N-10 Appeals (Continued)

THE FOLLOWING INFORMATION APPLIES TO BOTH
60 DAY APPEALS AND 72-HOUR APPEALS

Support for Your Appeal

You are not required to submit additional information to support your request for services or payment for services already received. *[Name of HMO]* is responsible for gathering all necessary medical information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your appeal. To obtain medical records, send a written request to your primary care physician. If your medical records from specialist physicians are not included in your medical record from your primary care physician, you may need to make a separate written request to the specialist physician(s) who provided medical services to you. *HMOs that have different procedures for members to follow in order to obtain medical records or physician opinions should describe them here. Please describe the process for obtaining medical records or physician opinions for the 72-hour appeal process. [Name of HMO]* will provide an opportunity for you to provide additional information in person or in writing.

Who May file an Appeal

1. You may file an appeal.

2. If you want someone to file the appeal for you:

a. Give us your name, your Medicare number, and a statement which appoints an individual as your representative. (Note: You may appoint a any provider.)
For example: "I *[your name]* appoint *[name of representative]* to act as my representative in requesting an appeal from *[name of HMO]* and/or the Health Care Financing Administration regarding *[name of HMO]'s* (denial of services) or (denial of payment for services).

b. You must sign and date the statement.

c. Your representative must also sign and date this statement unless he/she is an attorney.

d. Include this signed statement with your appeal.

3. A non-plan provider may file a standard appeal of a denied claim if he/she completes a waiver of liability statement which says he/she will not bill you regardless of the outcome of the appeal.

4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law.

Figure 2-20-N-10 Appeals (Continued)

Help With Your Appeal

If you decide to appeal and want help with your appeal, you may have your doctor, a friend, lawyer, or someone else help you. There are several groups that can help you. You may want to contact the Area Agency, on Aging at *[phone number]*, the Insurance, Counseling, and Assistance Program at *[phone number]*, the Medicare Rights Center at Toll Free 888-HMO-9050.

NOTE: In addition to the above sources of assistance, the State Ombudsman at *[phone number]* should be added to all SNF notices of noncoverage.

Figure 2-20-N-10 Appeals (Continued)

FOLLOWING ARE TWO QUALITY COMPLAINT PROCESSES WHICH ARE SEPARATE FROM THE APPEAL PROCESS DESCRIBED ABOVE.

Peer Review Organization Complaint Process

If you are concerned about the quality of the care you have received, you may also file a complaint with the local Peer Review Organization *[Name of PRO and phone number]*. Peer Review Organizations are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. The Peer Review Organization review process is designed to help stop any improper practices.

[HMO name] Quality Complaint Process

You may also file a written quality complaint with *[HMO name]*. *[Please describe your written procedures including time frames for investigating these types of complaints (called grievances).]* We will review your complaint and notify you in writing of our conclusion. This process is separate from the appeal described above. Please call *[phone number]* for additional information.

Figure 2-20-N-10 Appeals (Continued)

Attachment B2

MODEL APPEAL LANGUAGE FOR CLAIM DENIALS
(Must be 12 point type)

You Have a Right To Appeal

You can appeal if you do not agree with *[name of HMO or name of medical group]* decisions about your medical bills or health care. **You have a right to appeal if you think:**

- *[name of HMO or name of medical group]* has not paid a bill
- *[name of HMO or name of medical group]* has not paid a bill in full
- *[name of HMO or name of medical group]* will not approve or give you care it should cover
- *[name of HMO or name of medical group]* is stopping care you still need.

NOTE: If a medical group is issuing the denial notice with the required Model Appeal Language, whenever the word "we" is used it should be replaced with the name of the HMO.

60 - Day Appeal Process

If you want to file an appeal which will be processed within 60 days do the following:

- File the request in writing with [HMO name] at the following address: (_____), or with an office of the Social Security Administration, or if you are a railroad annuitant, with the Railroad Retirement Board.
- Mail, FAX, or deliver your request in person. *[please provide mailing address, and the address where hand delivered requests are received if different and FAX number]*
- File your request within 60 days of the [date of this notice] which is [date].
- See the following sections which apply to both the 60-day appeal and the 72-hour appeal: **"Support for Your Appeal, Who May File an Appeal, Help With Your Appeal, and Peer Review Organization Complaint Process"**

Even though you may file your request with the Social Security Administration or Railroad Retirement Board office, that office will transfer your request to *[name of HMO]* for processing. We are responsible for processing your appeal request within 60 days from the date we receive your request. If we do not rule fully in your favor, we will forward your appeal request to the Health Care Financing Administration's contractor (The Center for Health Dispute Resolution) for a decision.

Figure 2-20-N-10 Appeals (Continued)

Support for Your Appeal

You are not required to submit additional information to support your request for services or payment for services already received. *[Name of HMO]* is responsible for gathering all necessary medical information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your appeal. To obtain medical records, send a written request to your primary care physician. If your medical records from specialist physicians are not included in your medical record from your primary care physician, you may need to make a separate written request to the specialist physician(s) who provided medical services to you. *HMOs that have different procedures for members to follow in order to obtain medical records or physician opinions should describe them here. Please describe the process for obtaining medical records or physician opinions for the 72-hour appeal process. [Name of HMO]* will provide an opportunity for you to provide additional information in person or in writing.

Who May file an Appeal

1. You may file an appeal.

2. If you want someone to file the appeal for you:

a. Give us your name, your Medicare number, and a statement which appoints an individual as your representative. (Note: You may appoint a any provider.)
For example: "I *[your name]* appoint *[name of representative]* to act as my representative in requesting an appeal from *[name of HMO]* and/or the Health Care Financing Administration regarding *[name of HMO]'s* (denial of services) or (denial of payment for services).

b. You must sign and date the statement.

c. Your representative must also sign and date this statement unless he/she is an attorney.

d. Include this signed statement with your appeal.

3. A non-plan provider may file a standard appeal of a denied claim if he/she completes a waiver of liability statement which says he/she will not bill you regardless of the outcome of the appeal.

4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law.

Figure 2-20-N-10 Appeals (Continued)

SUGGESTED CLINICAL CRITERIA FOR AUTOMATIC EXPEDITED REVIEW*

1. All Appealed Rehab Hospital Continued Stay Denials.
2. All appealed SNF Continued Stay Denials.
3. All requests/denials for continued home health services.
4. All denials of Physical Therapy within 6 months of a CVA, head injury/surgery, or other acute trauma.
5. All first requests for Physical Therapy within 4 months of a CVA, head injury/surgery, or other acute trauma.
6. All denials for continuing Physical Therapy within 6 months of a major joint (e.g., hip, total knee) surgery.
7. All first requests for continuing Physical Therapy within 4 months of major joint surgery.
8. Requests/denials for chemotherapy, radiation therapy or proposed surgical treatment of a known malignancy.
9. Requests/denials of a proposed AIDS therapy in an AIDS patient.
10. Any denial of a proposed "experimental" treatment in a terminal patient. (Use California State Law in defining terminal.)
11. Any requests by a physician for urgent determination/recon review.
12. Any call where there is a refusal by the provider to proceed with a scheduled service/test because an authorization was not given on a service that has been scheduled. (E.g., surgery scheduled but no authorization issued on which to proceed.)

*All other pre-service cases would be judged case-by-case as to whether failure to grant an expedited review/denial could mean harm to the member if a possible 60 day wait was imposed.

Figure 2-20-N-11 HMO 2400. Distinguishing Between Grievances and Appeals

There are two types of procedures for resolving enrollee complaints, the Medicare appeals procedures and the plan-internal grievance procedures. Resolve all enrollee complaints through one of these procedures. Use the procedure appropriate to the complaint. Disputes about initial determinations, are resolved only through the Medicare appeals procedure. These are primarily complaints concerning payment for services or denial of services. Use the grievance procedures for all complaints which do not involve an initial determination. Transfer complaints between the two procedures when appropriate.

2400.1 *Complaints Which Apply Both to Appeals and Grievances.--The appeals and grievance procedures are mutually exclusive. Process complaints under the appeals procedures or grievance procedures. If an enrollee addresses two issues in one complaint, process each issue separately and simultaneously under the proper procedure. Do not process these complaints first through the grievance procedures, and then through the appeals procedures.*

2400.2 Appeals. *All initial determinations are subject to the appeals procedures. Complaints sometimes do not appear to involve an initial determination and are mis-classified as grievances. This may occur because the plan did not issue the written notice of an adverse determination. (See Section 2403.5.) Common mis-classifications include:*

A. ***Service Denials.****--Service denials are often mis-identified in cases in which:*

- *The provider of services made a coverage denial;*
- *A notice of adverse initial determination was not issued within sixty days; and*
- *The beneficiary appeals pursuant to Section 2403.1.*

Inform providers that they must ensure timely issuance of a written notice of adverse initial determination as described in 2403.5 when coverage is denied. The provider may issue the initial determination notice or he/she may ensure that the medical group or organization issues the notice.

B. ***Quality of Care.****--Complaints concerning the quality of a service a member received are treated as a grievance. However, quality of care complaints are occasionally complaints of a denial of services. For example, a member complains of poor medical care because his doctor did not authorize a surgery or other medical service. This complaint involves a denial of service. Process it through the appeals procedures. Peer Review Organizations (Pros) also review beneficiary quality of care complaints. (See 2305.1F.)*

Figure 2-20-N-11 HMO 2400. Distinguishing Between Grievances and Appeals (Continued)

*C. **Accessibility.**--Complaints concerning timely receipt for services already provided are treated as grievances. If the member complains that he has not been able to obtain a service, treat it as an appeal. If the member complains that he had to wait so long for a service that he went out-of-plan, treat it as an appeal for payment for the out-of-plan services.*

*D. **Non-Medicare Covered Services.**--The Medicare appeals procedures apply to all benefits offered under a risk-based contractor's basic benefit package. They also apply to Part A benefits which "Part B only" members buy from the plan. Benefits offered under an optional supplemental plan are subject only to the grievance procedures. (See Section 2403.2E.) Non-Medicare benefits in a cost-reimbursed contractor's basic benefit package are not subject to the appeals procedures.*

***2400.3 Claims Processed by Carriers and Intermediaries.**--Carriers or intermediaries receiving claims for members of risk-based plans transfer the claims to the plan for processing. Carriers and intermediaries sometimes correctly process claims for members of cost-reimbursed plans (i.e., when enrollees see a non-plan physician). Enrollees file for appeal with the entity that made the determination. For example:*

***A. Claims Denied by the Carrier or Intermediary.**--The enrollee files an appeal with that carrier or intermediary.*

***B. Claims Paid by the Carrier or Intermediary, but the Enrollee Disagrees with Payment Amount.**--The enrollee files the claim with the carrier or intermediary. For example, a member submits a claim for a motorized wheelchair. The carrier decides the motorized wheelchair was not medically necessary and reimburses the member at the rate approved for a non-motorized wheelchair. If the enrollee believes the motorized wheelchair was medically necessary, he/she appeals through the carrier.*

***C. Claims Paid by the Carrier or Intermediary and the Enrollee Wants Reimbursement for Coinsurance or Deductibles.**--Enrollees file appeals with the HMO/CMP if they agree with the carrier's or intermediary's decision, but disagree with the plan's reimbursement for the Medicare deductible and coinsurance. For example, the carrier processes a claim for a motorized wheelchair and pays 80% of the allowable charge. However, the plan issues an initial determination denying the deductible and coinsurance because the member purchased the wheelchair from a non-plan provider. The enrollee appeals to the HMO/CP for reimbursement. Process appeals on carrier or intermediary claims only in this situation.*

***2400.4 Grievances.**--The following items are not subject to the appeals procedures. Process them under the grievance procedures outlined in Section 2410:*

- *Disputes that do not meet the definition of an initial determination.*

Examples of grievances include:

Figure 2-20-N-11 HMO 2400. Distinguishing Between Grievances and Appeals (Continued)

- *Determinations of items or services included in an optional supplemental plan;*
- *Complaints about waiting times, physician demeanor and behavior, adequacy of facilities; or*
- *Involuntary disenrollment issues.*

• *Disputes about items or services that you have furnished, either directly or under arrangement, for which the enrollee has no further liability for payment (i.e. services rendered without charge or for which the responsibility for payment does not rest with the Medicare beneficiary). However, services for which Medicaid has paid or could pay are subject to appeal.*

HMO 2410. SCOPE OF GRIEVANCES

Process all member complaints which are not initial determinations through the grievance procedures. This includes complaints about coverage under an optional benefit package, waiting times, physician behavior and involuntary disenrollment concerns. Handle all disputes about initial determinations under the appeals procedures.

HMO 2411. PROCEDURES

Maintain internal grievance procedures. Provide the following procedures:

• *Transmit timely grievances and complaints to appropriate decision making levels in the plan;*

• *Take prompt, appropriate action, including a full investigation if necessary; and*

• *Notify concerned parties of investigation results.*

Figure 2-20-N-12 HCFA Working Aged Survey

HCFA Working Aged Survey

Name: _____ Social Security # _____
Address: _____ Phone # _____
City, State, Zip: _____

1. Please indicate your employment status (Check only one):
   WORKING FULL TIME ☐ WORKING PART TIME ☐ SELF EMPLOYED ☐
   ACTIVE DUTY ☐ RETIRED ☐ NOT EMPLOYED ☐

2. Do you have health insurance through your employer or your spouse's employer?
   NO ☐ (If NO, go to step 3 to sign and date this survey)
   YES, THROUGH MY EMPLOYER ☐ YES, THROUGH MY SPOUSE'S EMPLOYER ☐

   If YES, please tell us about your health insurance:
   Insurance Company Name: _____
   Insurance Company Address: _____
   Insurance Company City, State, Zip: _____
   Subscriber Name: _____
   Policy Number: _____
   Effective Date: _____ Termination Date: _____

   If YES, Please tell us about the employer providing this health insurance coverage:
   Employer Name: _____
   Employer Address: _____
   Employer City, State, Zip: _____
   Employee Id: _____
   Group Number: _____ Group Plan: _____

3. Signed: _____ Date: _____

Please contact your health plan if these answers change.

Figure 2-20-N-13 Data Element Requirements - Working Aged Information*

Field	Description
Claim Number	HIC Number
Last Name	Beneficiary Last Name
First Initial	Beneficiary First Name Initial
Sex	Beneficiary Sex Code
Date of Birth	Beneficiary Birth Date; format includes century
Contract Number	GHP Contract Number
MSP Coverage Indicator	Yes or No
Prior Commercial	Number of months a beneficiary was enrolled in Plan on a commercial basis prior to Medicare contract, if applicable
Transaction Type	Add or Change MSP Data Transaction, or Delete MSP Data Transaction
Insurer's Name	Primary Insurer's Name
Insurer's Address	Primary Insurer's Address
Policy Number	Primary Insurer's policy number of insured if available
MSP Effective Date	Effective date of MSP coverage
MSP Termination Date	Termination of MSP coverage
Patient Relationship	Relation of patient to insured (Patient is insured or Spouse)

* These are the data elements required, unless otherwise stated, to update the Working Aged information